

**County of Los Angeles – Department of Mental Health
Countywide Housing, Employment & Education Resource Development
Federal Housing Subsidies Unit (FHSU)**

Pre-Authorization Request for FHSU Housing Resource (S+C, HS8, TBSH, or HVI)

Before working on a housing application, please complete and fax this form to **Arielle Ventimiglia** at **213-252-8883**. FHSU will triage the referrals and determine the housing program your client will be assigned to: Shelter Plus Care, Homeless Section 8, Tenant Based Supportive Housing Program or Homeless Veterans Initiative.

Please DO NOT begin completing an application packet until you receive approval from FHSU.

Client Information (please print)

IS/IBHIS Number:		Date:		Date of Birth:		Social Security Number:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Client Last Name:			Client First Name:			Head of Household: <input type="checkbox"/> No <input type="checkbox"/> Yes		Veteran: <input type="checkbox"/> No <input type="checkbox"/> Yes	
								Housing Authority: <input type="checkbox"/> HACLA <input type="checkbox"/> HACoLA	
Enrolled in: <input type="checkbox"/> FSP <input type="checkbox"/> FCCS <input type="checkbox"/> IMHT <input type="checkbox"/> Wellness <input type="checkbox"/> Project 50 Replications <input type="checkbox"/> Other MH Program (explain): _____				Is Client prioritized through CES? <input type="checkbox"/> No <input type="checkbox"/> Yes		Priority Score (1-3)	SPDAT Score (0-17)	Family Size: # of Adults # of Minors	
								Total Monthly Household Income \$	
Income Source (check all that apply):									
<input type="checkbox"/> Earned Income		<input type="checkbox"/> Veteran's Disability		<input type="checkbox"/> Worker's Compensation		<input type="checkbox"/> CalWORKs or TANF			
<input type="checkbox"/> Unemployment Insurance		<input type="checkbox"/> Veteran's Pension		<input type="checkbox"/> General Assistance/ GR		<input type="checkbox"/> Pension from another job			
<input type="checkbox"/> SSI		<input type="checkbox"/> Child Support		<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) / Food Stamps		<input type="checkbox"/> Alimony (spousal support)			
<input type="checkbox"/> SSDI		<input type="checkbox"/> Private Disability Insurance				<input type="checkbox"/> Other (explain): _____			

Agency/Clinic Information (please print)

Agency/Clinic:		Housing Liaison/Case Manager:		Service Area:	
Email Address:		Phone Number:		Fax Number:	

History of Homelessness

Provide a **3-year timeline** of client's housing / homelessness history. Attach a separate sheet if necessary.

For FHSU staff use only. Please DO NOT complete below.

Client portion of the rent \$ _____ x 30% = \$ _____	Service cost: \$ _____
Subsidized portion of rent: \$ _____ - \$ _____ = \$ _____	
Is client chronically homeless as defined by HUD? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Meets service cost requirement. Accept an application for S+C.	
<input type="checkbox"/> Does not meet service cost requirement. Do not accept an application for S+C.	
_____ Signature of FHSU Staff	_____ Date